**Dementia**

**teleECHO™ Clinic Case Presentation Form**

Complete ALL ITEMS on this form and fax to 505-272-6906.

<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient First Name:</td>
</tr>
<tr>
<td>2.</td>
<td>Patient Last Name:</td>
</tr>
<tr>
<td>3.</td>
<td>Patient Birthday: (month/day/year)</td>
</tr>
<tr>
<td>4.</td>
<td>Patient Gender:</td>
</tr>
<tr>
<td>5.</td>
<td>Clinician Phone Number:</td>
</tr>
<tr>
<td>6.</td>
<td>Clinician Fax Number:</td>
</tr>
<tr>
<td>7.</td>
<td>Clinician Email:</td>
</tr>
<tr>
<td>8.</td>
<td>Clinic/Facility Name:</td>
</tr>
<tr>
<td>9.</td>
<td>Clinic/Facility City:</td>
</tr>
</tbody>
</table>

When do you want to present your case? Date and approximate time?

*When we receive your case, we will email or fax you a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.*

**PLEASE NOTE** that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO® setting.
Dementia TeleECHO Clinic

CASE PRESENTATION FORM

GENERAL INFORMATION

Date: ________________ Presenter: ____________________________________________ Clinical Site: ________________

Patient Name: ________________________________________________________________________________ ECHO ID: ______________________________

Age: ____ DOB: ______________ Gender: □ Male or □ Female

Check One: □ New Case or □ Follow-up Molina patient? □ Yes □ No

Occupation: __________________________ Educational Level ______________

WHAT IS YOUR MAIN QUESTION ABOUT THIS PATIENT?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Check all that apply (or relate to your main question) and fill in specifics:

☐ Specific symptom management (insomnia, wandering, paranoia, hallucinations, etc)

☐ Dementia specific treatment options __________________________________________________________

☐ Issues of Activities of Daily Living (ADLs) [Click here for the form]

☐ Issues of Instrumental Activities of Daily Living (iADLs) [Click here for the form]

☐ Determining the patient’s diagnosis __________________________________________________________

☐ Agitation and/or aggression _________________________________________________________________

☐ Advance care planning _____________________________________________________________________

☐ Inappropriate behavior _____________________________________________________________________

☐ Other(s) _________________________________________________________________________________

Brief History of Present Illness (may attach a recent clinic progress note): __________________________

Psychiatric hospitalization: □ Yes □ No Number of times: ______________________________

Current and Past Medical History (may attach a list): ____________________________________________

Current meds and therapies (may attach a list): _________________________________________________

Meds and therapies that have been tried in the past: ____________________________________________

Social history: ____________________________________________________________________________
REVIEW OF SYSTEMS

Please check all that apply:

- Insomnia
- Wandering
- Constipation
- Incontinence
- Anxiety
- Agitation
- Depression
- Drowsiness
- Other(s)

Physical Exam - Pertinent Findings:

Cognitive Screening Exam: Please attach findings

- SLUMS [Click here for the form]
- MMSE [Click here for the form]
- MoCA [Click here for the form]

MoCA Administration and Scoring Instructions [Click here for the form]

(MoCA©) is available from http://www.parkinsons.va.gov/consortium/moca.asp

- MINI-COG [Click here for the form]

Neuropsychology Test - (may attach a report):

Pertinent Labs and Imaging:

Patient's Decision Making Capacity:

- Decisional
- Not Decisional
- Not Sure

Other: ____________________________ For non-decisional patient: decisions are made by: ____________________________

Financial Concerns:

- No
- Not Sure
- Yes ____________________________

Goals of Care: (What is important to the patient/family?) ____________________________

_______________________________

_______________________________

_______________________________

Any other information that you think is important: ____________________________

_______________________________

_______________________________

_______________________________

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